BlueCross BlueShield

SUMMARY OF BENEFITS

PPO Blue® Options v.5

This health plan includes a tiered provider network called PPO Blue Options v.5. Members in this plan pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at **www.bluecrossma.com/findadoctor** and search for PPO Blue Options v.5.

MIIA Massachusetts Based Member Driven

✔ This plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

Your Choice

When You Choose Preferred Providers

You have the option of selecting in-network providers who are part of the PPO Blue Options network (preferred providers). You'll generally receive a higher level of benefits—and pay lower out-of-pocket costs—when you choose preferred providers. See the charts on the opposite and back pages for your cost share.

Within the network, certain preferred primary care providers and preferred general hospitals are ranked into three benefits tiers based on cost and nationally accepted quality performance criteria selected by Blue Cross Blue Shield of Massachusetts.

Where you receive care will determine your out-of-pocket costs for most services under the plan. By choosing Enhanced Benefits Tier preferred providers each time you get care, you can generally lower your out-of-pocket costs.

- Enhanced Benefits Tier—Includes preferred providers in Massachusetts that meet the standards for quality and are low cost relative to our benchmark. You pay the lowest out-of-pocket costs when you choose providers in the Enhanced Benefits Tier.
- Standard Benefits Tier—Includes preferred providers in Massachusetts that meet the standards for quality and moderate cost relative to our benchmark. This benefits tier includes preferred hospitals that do not meet the standards for quality but are low or moderate cost relative to our benchmark. You pay mid-level out-of-pocket costs when you choose providers in the Standard Benefits Tier. Also includes providers without sufficient data for measurement on one or both benchmarks. To ensure members have provider access in certain geographic areas, the Standard Benefits Tier includes some providers whose scores would otherwise put them in the Basic Benefits Tier.
- Basic Benefits Tier—Includes preferred hospitals in Massachusetts that are high cost relative to our benchmark. Also includes preferred primary care providers in Massachusetts who did not meet the standards for quality and/or are high cost relative to our benchmark. You pay the highest out-of-pocket costs when you choose providers in the Basic Benefits Tier.

Note: Primary care providers were measured based on their HMO patients as part of their provider group, and hospitals were measured based on their individual facility performance. Provider groups can be composed of an individual provider, or a number of providers who practice together. Tier placement is based on cost and quality benchmarks where measurable data is available. Preferred providers without sufficient data for cost and quality are placed in the Standard Benefits Tier. Preferred primary care providers that do not meet benchmarks for one or both of the domains and preferred hospitals that do not meet benchmarks for cost or that use nonstandard reimbursement are placed in the Basic Benefits Tier.

It is important to consider the tier of both your provider and the facility where your provider has admitting privileges before you choose a preferred primary care provider or receive care. For example, if you require hospital care and your Enhanced Benefits Tier preferred primary care provider refers you to an Enhanced Benefits Tier preferred hospital, you would pay the lowest cost sharing for both your provider and hospital services. Or, if your Enhanced Benefits Tier preferred primary care provider refers you to a Basic Benefits Tier preferred hospital for care, you will pay the lowest copayments for preferred primary care provider services, but the highest copayments for hospital services, except in an emergency.

How to Find a Preferred Provider

There are a few ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com/findadoctor**
- Call the Physician Selection Service at **1-800-821-1388**

Note: In some out-of-state PPO service areas, different levels of preferred providers may not be available. In this case, your cost share will be the same as it would be for an Enhanced Benefits Tier preferred provider.

When You Choose Non-Preferred Providers

You can also obtain covered services from out-of-network providers (non-preferred providers), but your out-of-pocket costs are higher. See the charts on the opposite and back pages for your cost share.

Your deductible is the amount of money you pay out-of-pocket each calendar year before you can receive coverage for most benefits under this plan. The calendar-year deductible begins on January 1 and ends on December 31 each year. Your out-of-network deductible is **$150** per member (or **$300** per family).

Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your benefit description. You may be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a calendar year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **$2,500** per member (or **$5,000** per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is **$1,000** per member (or **$2,000** per family).

Emergency Room

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). You pay a copayment per visit for in-network or out-of-network emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart on the opposite page for your cost share. Additionally, because you may not have a choice during an emergency, if you are admitted for an inpatient stay from the emergency room, you will be responsible for an Enhanced Benefits Tier copayment regardless of the tier of the hospital.

Utilization Review Requirements

You must follow the requirements of Utilization Review, including Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. For detailed information about Utilization Review, see your benefit description. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on y our ID card for pre-approval. If you do not notify Blue Cross Blue Shield of Massachusetts and receive pre-approval, your benefits may be reduced or denied.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care Routine physical exams, including related tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older	Nothing	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine GYN exams, including related tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine vision exam (one per calendar year)	Nothing	20% coinsurance after deductible
Family planning services–office visits	Nothing	20% coinsurance after deductible
Hearing Benefits Routine hearing exams, including related tests	Nothing	20% coinsurance after deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the benefit maximum	20% coinsurance after deductible and all charges beyond the benefit maximum
Outpatient Care Emergency room visits	$100 per visit (waived if admitted or for observation stay)	$100 per visit, no deductible (waived if admitted or for observation stay)
Primary care provider visits at an office or health center	Enhanced Benefits Tier: $10 per visit Standard Benefits Tier: $15 per visit Basic Benefits Tier: $20 per visit	20% coinsurance after deductible
Specialists and other covered provider visits	$25 per visit	20% coinsurance after deductible
Mental health and substance abuse treatment	$10 per visit	20% coinsurance after deductible
Chiropractors' office visits (up to 20 visits per calendar year)	$15 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy–physical, occupational, and speech (up to 90 visits per calendar year*)	$15 per visit	20% coinsurance after deductible
Home health care and hospice services	Nothing	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing	20% coinsurance after deductible
Prosthetic devices	Nothing	20% coinsurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing	20% coinsurance after deductible
Surgery and related anesthesia, when performed: • In an office setting	Enhanced Benefits Tier: $10 per visit** Standard Benefits Tier: $15 per visit** Basic Benefits Tier: $20 per visit** Other covered provider: $25 per visit**	20% coinsurance after deductible
• Ambulatory surgical facility, hospital, or surgical day care unit	All Tiers: $150 per admission	20% coinsurance after deductible
Diagnostic X-rays, lab tests, and other tests, excluding MRIs, CT scans, PET scans, and nuclear cardiac imaging tests	Nothing	20% coinsurance after deductible
MRIs, CT scans, PET scans, and nuclear cardiac imaging tests	All Tiers: $100 per category per date of service	20% coinsurance after deductible
Inpatient Care (and maternity care) General hospital care (as many days as medically necessary)	Enhanced Benefits Tier: $200 per admission Standard Benefits Tier: $400 per admission*** Basic Benefits Tier: $400 per admission***	20% coinsurance after deductible
Chronic disease hospital care (as many days as medically necessary)	$200 per admission	20% coinsurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$200 per admission	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% coinsurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	Nothing	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care, the treatment of autism spectrum disorders, or speech therapy.

** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

*** This cost share applies to mental health admissions in a general hospital.

Prescription Drug Benefits*	Your Cost In-Network**	Your Cost Out-of-Network
At retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 for Tier 1† $25 for Tier 2 $50 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$20 for Tier 1† $50 for Tier 2 $110 for Tier 3	Not covered

* Tier 1 generally refers to generic drugs; Tier 2 generally refers to brand-name drugs; Tier 3 generally refers to non-preferred drugs.
** Cost share waived for certain orally-administered anticancer drugs.
† Cost share waived for birth control.

Get the Most from Your Plan

Visit us at **www.bluecrossma.com/membercentral** or call **1-800-782-3675** to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Wellness Participation Program **Reimbursement for a membership at a health club or for fitness classes** This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details.)	$150 per calendar year per policy
Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details.)	$150 per calendar year per policy
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call **1-888-247-BLUE (2583)**	No additional charge

Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call **1-800-782-3675,** or visit us online at **www.bluecrossma.com.**

Interested in receiving information from us via e-mail? Go to **www.bluecrossma.com/email** to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders.

Note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

BlueCross® BlueShield®

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.emiia.org or by calling **1-800-782-3675**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0 in-network; $150 member / $300 family out-of-network. Does not apply to emergency room, emergency transportation, prescription drugs.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For medical benefits, $2,500 member / $5,000 family; and for prescription drug benefits, $1,000 member / $2,000 family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Does this plan use a network of providers?	Yes. See www.bluecrossma.com/findadoctor or call 1-800-821-1388 for a list of network providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about excluded services.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** (or provider's charge if it is less than the **allowed amount**) for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000 (and it is less than the provider's charge), your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network enhanced benefits tier **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you are eligible to elect a Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or you have elected a Health Savings Account (HSA), you may have access to additional funds to help cover certain **out-of-pocket** expenses such as **copayments**, **coinsurance**, **deductibles** and costs related to services not otherwise covered.)

Common Medical Event	Services You May Need	Your cost if you use				Limitations & Exceptions
		Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 / visit	$15 / visit	$20 / visit	20% coinsurance	Deductible applies first for out-of-network
	Specialist visit	$25 / visit	$25 / visit	$25 / visit	20% coinsurance	Deductible applies first for out-of-network
	Other practitioner office visit	$15 / chiropractor visit	$15 / chiropractor visit	$15 / chiropractor visit	20% coinsurance / chiropractor visit	Deductible applies first for out-of-network; limited to 20 visits per calendar year
	Preventive care/screening/immunization	No charge	No charge	No charge	20% coinsurance	Deductible applies first for out-of- network; limited to age-based schedule and / or frequency
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	No charge	20% coinsurance	Deductible applies first for out-of-network
	Imaging (CT/PET scans, MRIs)	$100	$100	$100	20% coinsurance	Deductible applies first for out-of-network; copayment applies per category of test / day

Common Medical Event	Services You May Need	Your cost if you use				Limitations & Exceptions
		Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier	Out-of-Network	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bluecrossma.com/medications.	Generic drugs	$10 / retail supply or $20 / mail service supply	$10 / retail supply or $20 / mail service supply	$10 / retail supply or $20 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$25 / retail supply or $50 / mail service supply	$25 / retail supply or $50 / mail service supply	$25 / retail supply or $50 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Non-preferred brand drugs	$50 / retail supply or $110 / mail service supply	$50 / retail supply or $110 / mail service supply	$50 / retail supply or $110 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Applicable cost share (generic, preferred, non-preferred)	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	$150 / admission	$150 / admission	20% coinsurance	Deductible applies first for out-of-network
	Physician/surgeon fees	No charge	No charge	No charge	20% coinsurance	Deductible applies first for out-of-network
If you need immediate medical attention	Emergency room services	$100 / visit	$100 / visit	$100 / visit	$100 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	No charge	No charge	--- none ---
	Urgent care	$25 / visit	$25 / visit	$25 / visit	20% coinsurance	Deductible applies first for out-of-network

Common Medical Event	Services You May Need	Your cost if you use				Limitations & Exceptions
		Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier	Out-of-Network	
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 / admission	$400 / admission	$400 / admission	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
	Physician/surgeon fee	No charge	No charge	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 / visit	$10 / visit	$10 / visit	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Mental/Behavioral health inpatient services	$200 / admission	$200 / admission for mental hospitals or substance abuse facilities ($400 for general hospitals)	$200 / admission for mental hospitals or substance abuse facilities ($400 for general hospitals)	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
	Substance use disorder outpatient services	$10 / visit	$10 / visit	$10 / visit	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Substance use disorder inpatient services	$200 / admission	$200 / admission for mental hospitals or substance abuse facilities ($400 for general hospitals)	$200 / admission for mental hospitals or substance abuse facilities ($400 for general hospitals)	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use				Limitations & Exceptions
		Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier	Out-of-Network	
If you are pregnant	Prenatal and postnatal care	No charge	No charge	No charge	20% coinsurance	Deductible applies first for out-of-network
	Delivery and all inpatient services	$200 / admission and no charge for delivery	$400 / admission and no charge for delivery	$400 / admission and no charge for delivery	20% coinsurance	Deductible applies first for out-of-network
If you need help recovering or have other special health needs	Home health care	No charge	No charge	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
	Rehabilitation services	$15 / visit	$15 / visit	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; limited to 90 visits per calendar year (other than for autism, home health care, and speech therapy)
	Habilitation services	$15 / visit	$15 / visit	$15 / visit	20% coinsurance	Deductible applies first for out-of-network; rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children
	Skilled nursing care	No charge	No charge	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to 45 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	No charge	No charge	20% coinsurance	Deductible applies first for out-of-network
	Hospice service	No charge	No charge	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use				Limitations & Exceptions
		Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier	Out-of-Network	
If your child needs dental or eye care	Eye exam	No charge	No charge	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to one exam per calendar year
	Glasses	Not covered	Not covered	Not covered	Not covered	--- none ---
	Dental check-up	No charge for members with a cleft palate / cleft lip condition	No charge for members with a cleft palate / cleft lip condition	No charge for members with a cleft palate / cleft lip condition	20% coinsurance for members with a cleft palate / cleft lip condition	Limited to members under age 18; deductible applies first for out-of-network

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Cosmetic surgery	• Long-term care
• Children's glasses	• Dental care (adult)	• Private-duty nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Infertility treatment	• Routine foot care (only for patients with systemic circulatory disease)
• Chiropractic care (20 visits per calendar year)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs ($150 per calendar year per policy)
• Hearing aids ($5,000 per ear every 36 months)	• Routine eye care - adult (one exam per calendar year)	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on your ID card or contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Assistance

To obtain language assistance, please call the toll-free Member Service number on your ID card.

SPANISH (Español): Para obtener asistencia en español, llame al número gratuito de Servicio de Atención al Miembro que figura en su tarjeta de identificación.

TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog tumawag sa libreng numero ng telepono ng Serbisyo sa Miyembro na nakasulat sa inyong ID card.

CHINESE (中文): 如果您需要中文語言幫助，請撥打會員卡上的客戶服務免費電話號碼

NAVAJO (Dine): Dinek'ehjí shika' a'dowoł ninizingo, kwojí hodiilné t'áá jííkeh béésh bee' hane'jį T'áá doolé'é bina'íshdiłkidgo yeeháká'adoojah éí binumber bee néého'dolzin biniiyé naanitinígíí bikáá' doo.

Disclaimer:

This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,970
- **Patient pays** $570

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$420
Coinsurance	$0
Limits or exclusions	$150
Total	**$570**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,220
- **Patient pays** $1,180

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,100
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,180**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from standard benefits tier providers. If the patient had received care from other in-network or out-of-network providers, costs would have been different.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-782-3675 or visit us at www.bluecrossma.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.bluecrossma.com/sbcglossary or call 1-800-782-3675 to request a copy.

MASSACHUSETTS

MCC Compliance

✔ This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

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MASSACHUSETTS

Information About the Plan

This health plan includes a tiered provider network called PPO Blue Options v.5. Members in this plan pay different levels of cost share (copayments, co-insurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at **www.bluecrossma.com/findadoctor** and search for PPO Blue Options v.5.

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